Christensen Chiropractic S.C.

Date _____

The United States government is now requiring that all healthcare providers collect demographic and health information from their patients. This is a confidential record of your health history.
It will never be released to any other party unless you provide us with direct, written authorization.
Thank you

Name _____ Date of Birth _____ Age_____

Address _____ City _____ State/Zip _____

Home Phone _____ Work Phone _____ Cell phone: _____

Cell Phone Carrier (if you would like appointment reminders via text message) _____

E-mail address: _____

What is your preferred method of contact?

Call to Home Call to Cell Text message to cell Email **(Please circle)**

Ethnicity:

Hispanic / Latino or Not Hispanic / Latino **(Please circle)**

Race: (Please circle)

White Black/African American Asian American Indian Native Hawaiian/Pacific Islander Two or more

Preferred Language: (Please circle)

English Spanish French German Italian Mandarin Cantonese Tagalog Japanese Other_____

Is your visit today caused by a work injury? _____ Date _____ Reported to your employer?_____

Is your visit today caused by a personal injury? _____ Date _____ Have you retained an attorney?_____

Who may we thank for referring you? _____

PATIENT CONDITION

Describe your current physical complaint(s) or symptoms. _____
_____
_____

Have you ever had this problem before? _____ When? _____ When did this problem start? _____

PRESCRIBED MEDICINES

Check here if not taking any medications**:** ☐

Medication (e.g Lipitor)	**# of MD refills issued**	**Quantity of Pills**	**Strength** (e.g.10 mg)	**Dose Form** (e.g. capsule)	**MD's instructions** (e.g. 1 per day)

Are you allergic to any medicines: Please list each drug below:
Check here if you do not have any medical allergies: ☐

Name of Drug (e.g. Penicillin)	**Symptoms**

List any surgeries you have had _____

Please describe any previous treatment or tests you've had for this problem:

Treatment	Name of Doctor/Facility	Results
❑ Chiropractor		
❑ Medial Doctor		
Tests		
❑ X-rays		
❑ MRI		
❑ CT scan		

Please Check all that apply:

- ❑ Headaches
- ❑ Neck Pain
- ❑ Dizziness
- ❑ Sinus Trouble/Allergies
- ❑ Elbow/wrist pain
- ❑ Pain between the shoulders
- ❑ Shoulder pain
- ❑ Pain/numbness in arm or hand
- ❑ Difficulty breathing
- ❑ Foot/ankle/knee pain
- ❑ Lower back pain
- ❑ Pain/numbness in legs and feet
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Constipation

Women Only: Are you pregnant? _____

Have you been diagnosed with either of the following:

Diabetes Asthma High Blood Pressure **(Please circle)**

Smoking Status:

Smokes every day Smokes some days Former Smoker Never Smoked **(Please circle)**

If you smoke, how many cigarettes do you smoke per day? _____

Please describe your immediate family members:

Family Member	If Living		If Deceased	
	Age	Health	Age at death	Cause
❑ Mother				
❑ Father				
❑ Brother/Sister				
❑ Brother/Sister				
❑ Brother/Sister				

- I hereby consent to treatment by the doctors at Christensen Chiropractic. If applicable, I hereby consent to have treatment provided for my minor child.
- I understand that any applicable insurance forms will be submitted by this clinic with full documentation of services performed, and that I am ultimately responsible for payment of services rendered
- I authorize all benefits provided by my insurance plan(s) to be paid directly to Christensen Chiropractic on my behalf.
- I understand a 1% per month (12% per year) late payment fee will be assessed on any unpaid balance after 30 days from date of statement**.**

_____ _____

Signature Date

_____ _____

Signature of parent or guardian in under 18 Date

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Pain Evaluation

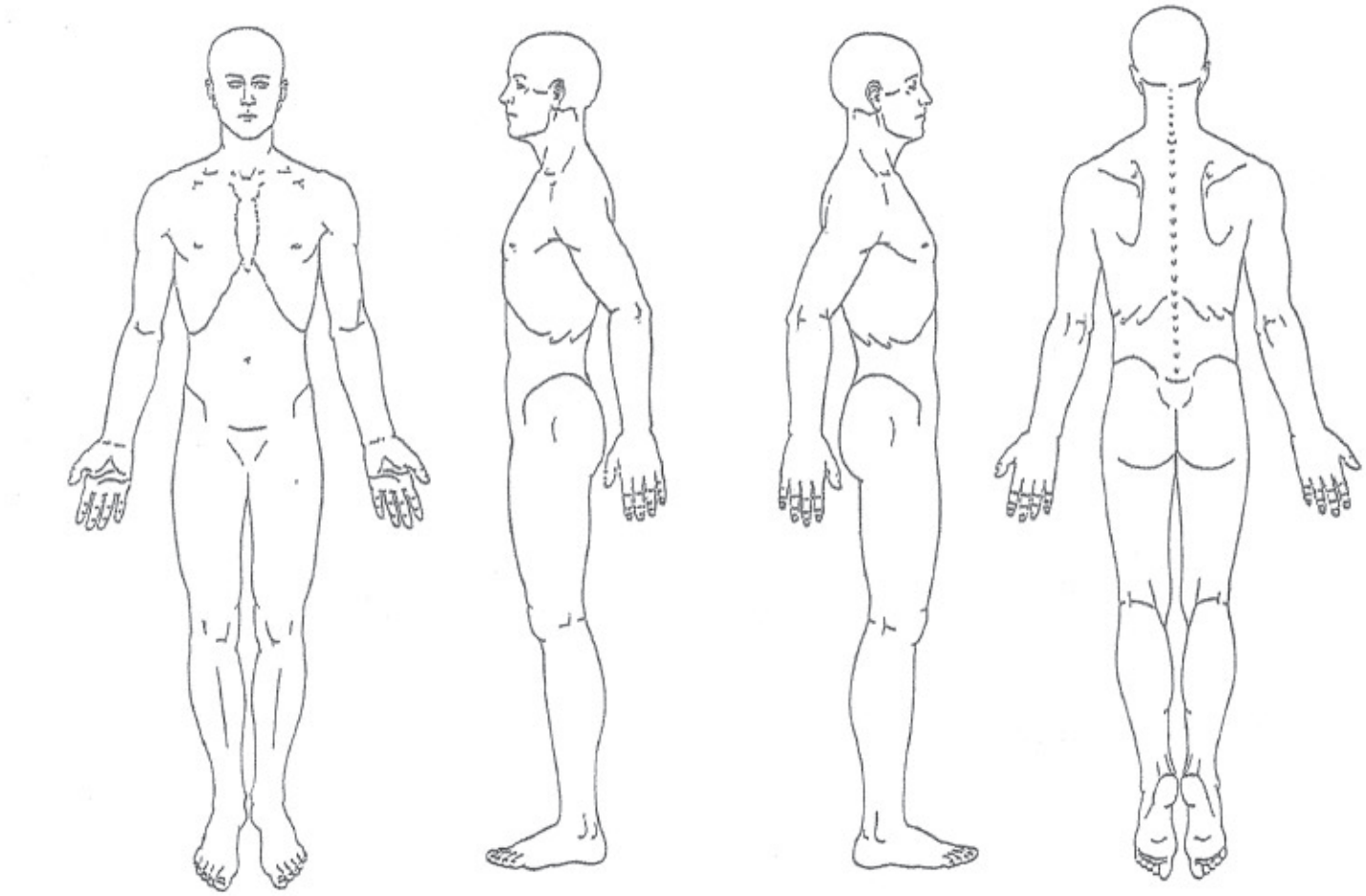
Christensen Chiropractic S.C.

Name: _____ Date: _____

1. Shade in the areas on the diagrams which are painful or uncomfortable for you.

2. Grade the areas of pain or discomfort on a scale from 1 to 10.
   (1 being "just noticeable" pain and 10 being the worst pain imaginable)

3. Make an "x" to represent your overall level of pain or discomfort on the line at the bottom of the page.



Overall Pain or Discomfort Scale

(No Pain) _____ (Worst Pain Imaginable)

Christensen Chiropractic S.C.

INFORMED CONSENT TO CHIROPACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Monica S. Christensen, DC and/or other licensed doctor's of chiropractic who now or in the future may practice in or be employed by Christensen Chiropractic, 1200 Nygaard Street, Suite 202 Stoughton WI 53589.

I have had an opportunity to discuss with Dr. Christensen the nature and purpose of chiropractic adjustments and other procedures.

The following points have been explained to me, to my satisfaction, and I have had opportunity to discuss them with Monica S. Christensen, DC and/or other clinic personnel:

- Chiropractic care is the science, philosophy and art of locating and correcting spinal and extremity joint dysfunction (aka: subluxation), and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurologic aspects. There has been no promise, implied or otherwise of a cure for any symptom, disease, or condition as a result of treatment in this clinic. If during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, a diagnosis or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

- I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".

- As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

- It is not reasonable to expect my chiropractor to be able to anticipate, or explain all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.

- An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.

- As with any health care procedure there are certain complications which may arise during a chiropractic adjustment, traction, manual therapy" massage therapy, ice or heat. Those complications include, but are not limited to, sprain/strain, dislocation, fractures, disc injuries, or cerebral-vascular accidents (stroke). The most recent studies (Journal of CCA, Vol. 37, No.2, June 1993) estimate that the incident of this type of stroke is a rare occurrence.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to chiropractic treatment and management on that basis.

_____ _____

Patient's Printed Name Date

_____ _____

Patient's Signature Parent/Guardian Date